

Office of Education and Vocational Rehabilitation

1 Congress St. Suite 100, Boston Massachusetts 02114 Information Line (800) 323-3249 ext. 280 in Massachusetts (617) 727-4900 ext. 280 Outside Massachusetts http://www.mass.gov/dia/oevr

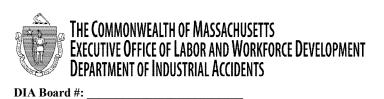
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DIA Board #:

INDIVIDUAL WRITTEN REHABILITATION PROGRAM

Please Print or Type

Client Name:	V.R.	V.R. Provider:				
Street Address:	Street	Street Address:				
City, State, Zip:	City,	City, State, Zip:				
Tel. Number:						
		V.R. Counselor:				
Pre-Injury Wage: \$	Insur	Insurer:				
Vocational Goal	Claim	Claims Representative:				
DOT Code:	Tel. Number:					
Date of Injury:						
LEVEL OF SERVICE - Employment Goal: (Job Place	ement, Job Modi	fication, OJT,	Training)			
VOCATIONAL SERVICES PLANNED & COST: F	<u>rrom</u>	<u>TO</u>	ESTIMATED COST			
Vocational Counseling and Guidance			\$			
Job Seeking Skills Training (with Resume prep.)			\$			
Transferable Skills			\$			
Job Modification (former Employer)			\$			
Vocational Training (including formal classes)			\$			
On-the-job Training			\$			
Job Development & Placement			\$			



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VOC. SERVICES PLANNED & COST (CONTINUED):	FROM	<u>TO</u>	ESTIMATED COST		
Post-Placement Follow-up			\$		
Transportation			\$		
Program Completion Date	e:	Total Est. Cost:	\$		
<u>Program Justification</u> : Submit a comprehensive case analysis of the injured worker, including such things as possible obstacles to rehabilitation, financial and family concerns, level of motivation, personal interests and avocations, and the necessary ingredients for asuccessful placement. Include injury restrictions, new job goal, why goal is appropriate, expected placement, salary and growth, injured worker's responsibilities, and VR provider responsibilities. (Attach extra sheets if needed).					
EMBLOVEE'S DESDONGIBLETY, I: 11	- 1 C-141 CC4141-	-111			
EMPLOYEE'S RESPONSIBILITY: I will cooperate and make a good faith effort with all parties involved in my rehabilitation program. This includes the keeping of all appointments and adherence to reasonable requests. I understand that any aspect of my program can be amended with good reason.					
SIGNED DA	ΓΕ				
<u>CERTIFIED VR PROVIDER RESPONSIBILITY</u> : I will be responsible for timely delivery of the above-referenced services and agree to carry out my professional duties in the interest of the employee's rehabilitation. I understand that this plan cannot be implemented without the approval of the Office of Education and Vocational Rehabilitation of the Department of Industrial Accidents. Should timelines or costs change in this program, I will notify the key parties and develop a program amendment.					
SIGNED DA	ГЕ				
EMPLOYER/INSURER RESPONSIBILITY: I agree to pay for all timeliness of services.	reasonable and nec	essary VR services	s, and to monitor the costs and		
SIGNED DA'	ГЕ				
OEVR RESPONSIBILITY: I will monitor the delivery of VR services to insure compliance with regulations and policy, ensure cost-effectiveness and quality of services. I agree to conduct team meetings to resolve any conflicts or issues amongst the key parties with respect to VR in a fair, objective and timely manner					
SIGNED DA'	ГЕ				